Lucile Packard Children's Hospital

HEALTH INFORMATION MGMT • **AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

Please send request to:
Lucile Packard Children's Hospital (LPCH)
Medical Records - Rm 0252A, MC 5906
725 Welch Rd, Palo Alto, CA 94304 – 5654
Phone: (650) 497-8079

This authorization is for the use or disclosure of health information pertaining to:

Patient's Name: Last: _____ *First* _____ *MI* _____

DOB: _____ *Phone Number:* _____ *MRN:* _____

I hereby authorize: ☒ LPCH, 725 Welch Road, Palo Alto, CA 94304

☐ (Other Healthcare Provider)_____

To disclose health information to:

CHILDREN'S HOSPITAL LOS ANGELES | Attn Medical Records 4650 Sunset Blvd MS#46 Los Angeles, CA 90027

(Name of Person or Organization Receiving Information) *Mailing Address* *City* *State* *Zip Code*

☒ Mail recs./film/CD by regular mail ☐ Pick-up at the Hospital ☐ Inspect records in person.

Under certain circumstances, LPCH may deny your request to inspect and/or copy your health information. If access is denied, you may request that the denial be reviewed. Instructions for the review process will be included with any denial. **Certain health information obtained from adolescents is confidential and is protected under the confidentiality laws of the State of California. For minors who are adolescents, the physician may choose not to release confidential information in the interest of the doctor-patient relationship or the health and safety of the patient.**

This authorization applies to the following information:

☒ Medical Records *(Specify):* all inpatient & outpatient medical records, laboratory tests, radiology reports and other diagnostic evaluations.

☒ Radiology Film/CD *(Requests will be forwarded to the Film Library for processing. For questions call 650-497-8578)* CD-ROM or film copies of all neuroimaging studies including head and spine MRI and CT scans.

☐ Billing Records *(If requesting for BILLING RECORDS ONLY, please mail directly to the LPCH Billing Dept, 2690 Hanover Street, Palo Alto, CA 94304. For questions, please call 650-497-8123)*

☐ Other Health Information *(Specify):*_____

A specific authorization is required to disclose information regarding the following:
(Check box and sign to specify information to be disclosed) *Signature*

☐ Psychiatric/Mental Health _____

☐ Drug/Alcohol Abuse _____

☐ HIV Lab Test Result _____

☐ Genetic/Fertility _____

The recipient may use the health information authorized on this form for the following purpose:
(Specify): _____

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- I may refuse to sign and my refusal will not affect my ability to obtain treatment, payment enrollment, or eligibility for benefits.
- The recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless the use or disclosure is specifically permitted by law If further use or redisclosure by the recipient is permissible, the information may no longer be protected by the federal privacy law (HIPAA).
- This authorization shall become effective immediately and shall remain in effect until _____ (If no date is given, authorization is valid for 6 months only from signature date).
- I reserve the right to withdraw or revoke this authorization, in writing, at any time, except to the extent that LPCH has already disclosed the information. I must submit my revocation to LPCH HIMS Dept., 725 Welch Rd, Rm 0252A, MC 5906, Palo Alto, CA 94304 – 5654

I understand that I have a right to receive a copy of this authorization.

Signature: _____ Date: _____

If signed by other than patient, indicate legal relationship:

_____